asymptomatic, but pose significant risk for long-term sequelae. Urban communities, including the Bronx, are disproportionately affected. Primary care providers are well positioned to identify and treat STIs, yet many adolescents are not screened. The purpose of the Bronx Ongoing Pediatric Screening (BOPS) project is to improve rates of screening across 4 domains (newborn genetic, metabolic and infectious diseases; infant/toddler screening for developmental and social/emotional disorders; school age and adolescent mental health; and STIs) in a large Bronx primary care network. We report changes in screening for sexual activity and STIs (N. Gonorrhea, C. Trachomatis [GC] and HIV) among youth age 13-19.

Methods: Intervention: BOPS, launched in March 2011, combines a modified learning collaborative, real-time clinical data feedback to practitioners and staff, quality improvement coaching, and a pay-for-quality monetary incentive using multidisciplinary onsite teams. Design: Comparison of 10 BOPS-participating sites (intervention) to 8 non-participating sites (control). Setting: A hospital-owned ambulatory network in the Bronx, NY. Main Outcomes/Measures: Rates of assessing sexual activity and ordering GC and HIV testing as documented in the adolescent template of the shared EMR; results of screening abstracted from the hospital's clinical information systems.

Results: Baseline rates of screening for GC and HIV varied across practices (16% to 84%, and 33% to 68%, respectively.) Between March 2011 - May 2013, the quarterly rate (median of weighted averages) of documented sexual activity during visits (in the EMR adolescent template) increased from 37% to 84% at BOPS sites and from 7% to 62% at non-BOPS sites. Among youth with sexual history documented as sexually active, quarterly screening rates for GC increased from 67% to 86% at BOPS sites and from 38% to 78% at non-BOPS sites. Among sexually active youth, HIV screening increased from 54% to 74% at BOPS sites and from 33% to 70% at non-BOPS sites. Among all youth with a visit to a BOPS site (not only those with documented sexual history), the annual proportion of GC tests to individuals increased from 15.4% pre-intervention [2010] to 19.8% in 2011, and to 34.7% in 2012. The proportion steadily increased for males (2010-12.3%, 2011-16.4%, 2012-25%) and females (2010-17.9%, 2011-22%, 2012-42.8%). At non-BOPS sites, the proportion of GC tests to individuals also improved from 12.1% pre-intervention to 14.7% in 2011 and 23.8% in 2012; the proportion increased less for males (2010-9.8%, 2011-11%, 2012-16.4%) than for females (2010-14%, 2011-17.8%, 2012-30.3%).

Conclusions: Our findings demonstrate that focused quality improvement (QI) efforts involving learning collaboratives, improvement coaching, EMR-generated data feedback and multidisciplinary teams improve documentation of sexual activity and increase rates of STI screening for both male and female adolescents. Data from non-participating sites suggests that introduction of an adolescent template in the EMR results in improvement in screening rates regardless of participation in the BOPS collaborative; BOPS activities appear to promote additional improvement, especially for screening of adolescent males.

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122.

ELEVATED SEXUAL RISK BEHAVIORS AMONG POST-INCARCERATED YOUNG AFRICAN AMERICAN MALES IN THE SOUTHERN UNITED STATES

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Purpose: Young African American males continue to be disproportionally likely to acquire sexually transmitted infections (STIs) including Human Immunodeficiency Virus (HIV). This problem is exacerbated in the Southern U.S. STI rates are consistently higher for incarcerated or recently arrested persons including youth compared to those never incarcerated. However few studies have specifically examined the sexual-risk taking behaviors of young African American males post-release from incarceration. The purpose of this study was to determine whether young African American males, residing in the Southern U.S., who had been incarcerated in the past, reported recent sexual behaviors that were relatively more risky than their counterparts who had never been incarcerated.

Methods: African American males 15-23 years of age experiencing recent sexual intercourse were recruited from STI clinics in three Southern U.S. cities for an NIH-funded randomized controlled trial of a safer sex intervention program. Baseline data were used for this analysis. An audio survey was administered which assessed sexual risk behaviors and history of incarceration. Bivariate associations were conducted utilizing t-tests for continuous sexual risk behaviors and contingency table analysis for dichotomous sexual risk behaviors. Subsequently, a series of linear regression models were used to create age-adjusted associations for continuous sexual risk behaviors and incarceration history. Similarly, a series of logistic regression models were used to create age-adjusted associations for dichotomous sexual risk behaviors.

Results: 607 participants completed surveys. Past incarceration was strongly associated with all continuous-level outcomes for sexual risk-taking behaviors except, number of partners in past 2 months. Young men having experienced incarceration had more occurrences of sexual intercourse where alcohol or drugs were used (P Value = .001), and more episodes of unprotected sex (mean = 5.57 vs. 0.45 respectively, P = .015) compared to those never incarcerated. Significant positive associations were demonstrated between past incarceration and exchange of sex for drugs ($P < .001$) or money (P = 0.007). Interestingly there was a significant negative association between past incarceration and sex with male partners in the preceding two months (P = .02). History of past incarceration did not influence self-report of past positive gonorrhea or chlamydia testing (P = .25). Linear regression controlling for age demonstrated, past history of incarceration was independently predictive of alcohol use before sex, being high while having sex, frequency of unprotected sex and desire to conceive a pregnancy ($P < .001$, $< .001$, and = .005 respectively). Additionally, number of sex partners in the past 2 months trended toward significance (P = .09). History of incarceration remained negatively predictive for sex with male partners (AOR .51). Past incarceration remained strongly predictive of exchange of sex for drugs or money (AOR = 1.32, P = .001 and AOR = 2.23, P = .01 respectively). Self report of past positive gonorrhea or chlamydia test results remained non-significant.

Conclusions: Young African American males with history of incarceration demonstrated consistently significantly increased sexual risk-taking post incarceration compared to their never incarcerated peers. These insights are important because they can be used to

advocate for and tailor post-incarceration STI/HIV prevention efforts, which are currently lacking for this high-risk population.
Sources of Support: Support provided by the National Institutes of Allergies and Infectious Diseases, to author: Crosby, R. # 5 R01 AI068119.

123.

MEDIEVAL WENCHES AND OTHER ICKY CONNOTATIONS: HOW YOUNG PEOPLE'S CONSTRUCTIONS OF SEXUALLY TRANSMITTED INFECTIONS DEEPEN OUR UNDERSTANDING OF THEIR SEXUAL HEALTH

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Purpose: Genital chlamydia infection mainly affects young people and can have long term health consequences. Despite Australian guidelines recommending chlamydia screening for all sexually active young people, testing rates remain low and the epidemic continues to grow. This qualitative study involved interviews with participants from a randomized controlled trial and employed Foucauldian discourse analysis to explore in depth how young people understand sexually transmitted infections (STIs) and the subject positions they take in relation to testing, diagnosis and communication with partners.
Methods: Young people (16 − 25 years) who completed a randomised controlled trial about a chlamydia testing intervention were invited to take part in a subsequent, qualitative study using in-depth interviews. The interviews were unstructured but guided by topic prompts and explored participants' views on chlamydia testing and the meanings attributed to STIs. The interviews were audio-recorded and transcribed. Two researchers read and analysed the transcripts in order to describe the discursive fields and subject positions taken by participants when discussing their understandings and experiences of STIs. The study was approved by the relevant ethics committee.
Results: Seven young people (5 female, 2 male) participated in in-depth interviews. Sources of knowledge, information seeking and interpersonal communications about STIs were constructed as proximal or distant and these constructs played different roles when coming to terms with STIs. Participants were more comfortable discussing STIs with close friends than with sexual partners and took up a position of caring for others in doing so. The medical consulting room was seen as the most appropriate place to get personal advice but even here proximity and distance played out. STIs were unanimously constructed as negative entities in participants' lives. However as their proximity to STIs increased, the struggle to resist these negative beliefs led to taking up a new subject position of caring for self. Participants unanimously attributed their negative beliefs about STIs to sexual activity itself. Sexual activity among young people, especially females, was taboo. Within the discourse of shame, participants found ways to resist being positioned in negative ways by carefully choosing others with whom they could discuss STIs, by taking up roles as informal peer educators or by gradually rejecting notions of guilt, shame or immorality. Participants produced subject positions for individual STIs. Not all STIs were equally negative. Different STIs had different meanings including 'gross' 'disgusting', 'serious', 'scary', a 'medieval wench' and 'having icky connotations'.
Conclusions: By emphasising 'risks' associated with sexual activity, health and education professionals could be reinforcing negative discourses about shame. Instead, approaches to STIs could acknowledge the struggle young people face in resisting negative discourses about their own sexual activity. By focusing on positive concepts such as caring for self and caring for others, young people might find safer spaces to seek help and discuss STIs with their partner/s and health care providers.
Sources of Support: The study was supported by a grant from the Australian Commonwealth Department of Health and Ageing.

HEALTH DISPARITIES

124.

SOCIODEMOGRAPHIC DISPARITIES IN PATIENT EXPERIENCE AMONG YOUNG AND OLDER US ADULTS

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Purpose: Experience of healthcare in early adulthood may influence lifelong attitudes to health and health-seeking behaviour. Poor healthcare experience may be a key contributing factor to health disparities. This study investigates disparities in patient experience by household income and race/ethnicity among younger and older American adults.
Methods: We used logistic regression to compare the proportion of young/older adults among different sociodemographic groups who reported positive healthcare experience in the Consumer Assessment of Healthcare Providers and Systems survey (CAHPS). Participants: Adults in the Medical Expenditure Panel Survey 2008 (1333 aged 18-24, 11986 aged over 25). Principal variables: Age, household income quintile (derived from ranking the percentage of poverty level for family composition), and race/ethnicity (Hispanic, Black, Asian, Other (including non-Hispanic White)). Covariates: Sex, number of care episodes. Outcomes: A dichotomous outcome was created for overall care rating (0-8 vs. 9-10 on a scale of 0-10). Additionally, participants reported whether, over the previous year, healthcare providers had always: listened, explained clearly, respected them, and spent enough time. Models: Within each age group, unadjusted models compared patient experience by income and race. Adjusted models used all covariates and investigated interactions between age and income/race.
Results: Young adults reported poorer patient experience than older adults on all outcomes (Overall rating 40.6 vs. 49.6% (Odds ratio = 0.69 (95% CI 0.62-0.78), $p < .001$); Listening 54.8 vs. 59.7% ($p = .001$); Explaining 52.6 vs. 59.9% ($p < .001$); Respect 59.3 vs. 62.7% ($p = .02$); Time 44.3 vs. 49.7% ($p < .001$)). For each outcome, younger age remained significantly associated with poorer care ($p < .05$) after adjusting for all covariates. Among young adults, the second poorest quintile reported the worst experience of care, with significantly lower proportions reporting each outcome than the richest quintile (Overall Rating 35.9 vs. 46.7% ($p = .02$); Listening 48.9 vs. 62.4% ($p = .003$); Explaining 47.3 vs. 62.0% ($p = .001$); Respect 55.8 vs. 65.8% ($p = .02$); Time 39.0 vs. 55.8% ($p < .001$)). These remained significant ($p < .02$) in the adjusted model. For all outcomes, there was a significant interaction between age and income, with greater disparity in patient experience between income groups among young adults ($p < .05$). Compared to the 'Other' group, young Asian-Americans reported poorer experience on all measures except for Explaining, and these differences remained significant in the adjusted model ($p <= .03$). Differences were also seen between Hispanics and Others but the effect disappeared or was of marginal significance in the adjusted model. For Overall Rating and Respect, the difference between Asians